CLIENT INFORMATION

Date_____

Name_____ Phone (H)_____ Phone (C)_____

Address_____ City_____ State_____ Zip_____

Date of Birth_____ Occupation_____

Emergency Contact_____ Phone_____

Referred By: _____

Have you had a professional massage before? Yes No How recently? _____

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?

_____

Do you perform any repetitive movement in your work, sports or hobby? Please describe:

_____

Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) contact lenses
( ) dentures
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) pregnancy # months_____
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) varicose veins
( ) any other medical conditions or medications

Please explain any condition that you have marked above _____

_____

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability of the therapist's part should I fail to do so.

Client Signature _____ Date_____

Consent to Treatment of Minor: By my signature below, I hereby authorize Stacey Welch to administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date_____